DSH Version 6.02 2/10/2023

eral DSH Year Information

	Begin	End
H Year:	07/01/2025	06/30/2026

lect Your Facility from the Drop-Down Menu Provided: WILLS MEMORIAL HOSPITAL

ntification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
st Report Year 1	05/01/2023	04/30/2024
st Report Year 2 (if applicable)		
st Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
dicaid Provider Number:	000002087A
ledicaid Subprovider Number 1 (Psychiatric or Rehab):	0
ledicaid Subprovider Number 2 (Psychiatric or Rehab):	0
dicare Provider Number:	111325

l Qualifying Information

estions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

	DSH Examination Year (07/01/25 - 06/30/26)
ring the DSH Examination Year:	
l the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to vide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital ated in a rural area, the term "obstetrician" includes any physician with staff privileges at the spital to perform nonemergency obstetric procedures.)	Yes
is the hospital exempt from the requirement listed under #1 above because the hospital's atients are predominantly under 18 years of age?	No
is the hospital exempt from the requirement listed under #1 above because it did not offer non-ergency obstetric services to the general population when federal Medicaid DSH regulations re enacted on December 22, 1987?	No
is the hospital open as of December 22, 1987?	Yes
iat date did the hospital open?	3/27/1978

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

Isclosure of Other Medicaid Payments Received:

Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026 *(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)*	$ 15,683
Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026 *(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.* *NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.*	$ -
Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2025 - 06/30/2026	$ 15,683

fication:

	Answer
Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.	Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	Title	Date
	CEO	2/6/2026

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Tracie Haughey	706-678-9213	thaughey@willsmemorialhospital.com

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:

Name	Tracie Haughey
Title	CEO
Telephone Number	706-678-9213
E-Mail Address	thaughey@willsmemorialhospital.com
Mailing Street Address	120 Gordon Street
Mailing City, State, Zip	Washington, GA 30673

Outside Preparer:

Name	Wilson E. Joiner, III
Title	Partner
Firm Name	Dralfin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bjoiner@dralfin-tucker.com

DSH Version 9.02 4/22/2025

General Cost Report Year Information 5/1/2023 - 4/30/2024

Following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

. Select Your Facility from the Drop-Down Menu Provided:	WILLS MEMORIAL HOSPITAL
. Select Cost Report Year Covered by this Survey (enter "X"):	5/1/2023 through 4/30/2024: X
. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted
. Date CMS processed the HCRIS file into the HCRIS database:	8/20/2024

	Data	Correct?	If Incorrect, Proper Information
. Hospital Name:	WILLS MEMORIAL HOSPITAL	Yes	
. Medicaid Provider Number:	000002087A	Yes	
. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
. Medicare Provider Number:	111325	Yes	
. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 1	Yes	
. Rural Referral Center (Yes or No)	No	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
. State Name & Number		
. State Name & Number		
. State Name & Number		
. State Name & Number		
. State Name & Number		
. State Name & Number		
. State Name & Number		

(List additional states on a separate attachment)

Disclosure of Medicaid / Uninsured Payments Received: (05/01/2023 - 04/30/2024)

. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 8,504	$ 62,340	$70,844
. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 20,478	$ 217,657	$238,135
. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$28,982	$279,997	$308,979
. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	29.34%	22.26%	22.93%

. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 ients Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

MIUR / LIUR Qualifying Data from the Cost Report (05/01/2023 - 04/30/2024)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	582	(See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	$ -
7. Inpatient Hospital Charity Care Charges	70,758
8. Outpatient Hospital Charity Care Charges	315,825
9. Non-Hospital Charity Care Charges	
0. Total Charity Care Charges	$ 386,583

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

E: All data in this section must be verified by the hospital. If data is ady present in this section, it was completed using CMS HCRIS cost rt data. If the hospital has a more recent version of the cost report, data should be updated to the hospital's version of the cost report. nulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
1. Hospital	$398,175.00			$ 145,398	$ -	$ -	$ 252,777
2. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
3. Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
4. Swing Bed - SNF			$642,624.00			$ 234,661	
5. Swing Bed - NF			$0.00			$ -	
6. Skilled Nursing Facility			$0.00			$ -	
7. Nursing Facility			$0.00			$ -	
8. Other Long-Term Care			$0.00			$ -	
9. Ancillary Services	$3,805,088.00	$10,003,045.00		$ 1,389,466	$ 3,652,712	$ -	$ 8,765,954
0. Outpatient Services		$3,884,564.00			$ 1,418,488	$ -	$ 2,466,076
1. Home Health Agency			$0.00			$ -	
2. Ambulance			$ -			$ -	$ -
3. Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
4. ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
5. Hospice			$0.00			$ -	
6. Other	$0.00	$0.00	$2,991,479.00	$ -	$ -	$ 1,092,369	$ -
7. Total	$ 4,203,263	$ 13,887,609	$ 3,634,103	$ 1,534,864	$ 5,071,200	$ 1,327,029	$ 11,484,808
8. Total Hospital and Non Hospital		Total from Above	$ 21,724,975		Total from Above	$ 7,933,093	

9. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	21,724,975	Total Contractual Adj. (G-3 Line 2)	7,286,311
0. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
1. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
2. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	646,782
3. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
4. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
5. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
6. Adjusted Contractual Adjustments				7,933,093
7. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
Routine Cost Centers (list below):										
03000	ADULTS & PEDIATRICS	$ 4,670,164	$ -	$ -	$2,558,191.00	$ 2,111,973	1,327	$884,230.00		$ 1,591.54
03100	INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
04300	NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
		$ -	$ -	$ -		$ -	-	$0.00		$ -
	Total Routine	$ 4,670,164	$ -	$ -	$ 2,558,191	$ 2,111,973	1,327	$ 884,230		
	Weighted Average									$ 1,591.54

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
Observation Data (Non-Distinct)									
09200	Observation (Non-Distinct)	745	-	-	$ 1,185,697	$7,520.00	$733,980.00	$ 741,500	1.599052

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
5000	OPERATING ROOM	$240,639.00	$ -	$ -		$ 240,639	$6,409.00	$97,865.00	$ 104,274	2.307756
5400	RADIOLOGY-DIAGNOSTIC	$1,284,428.00	$ -	$ -		$ 1,284,428	$423,480.00	$2,976,120.00	$ 3,399,600	0.377817
6000	LABORATORY	$1,510,763.00	$ -	$ -		$ 1,510,763	$531,887.00	$1,935,824.00	$ 2,467,711	0.612212
6500	RESPIRATORY THERAPY	$1,727,938.00	$ -	$ -		$ 1,727,938	$465,930.00	$1,428,769.00	$ 1,894,699	0.911985
6600	PHYSICAL THERAPY	$914,636.00	$ -	$ -		$ 914,636	$404,952.00	$855,175.00	$ 1,260,127	0.725828
6700	OCCUPATIONAL THERAPY	$299,757.00	$ -	$ -		$ 299,757	$401,059.00	$126,560.00	$ 527,619	0.568132
6800	SPEECH PATHOLOGY	$80,338.00	$ -	$ -		$ 80,338	$32,241.00	$7,392.00	$ 39,633	2.027048
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$242,092.00	$ -	$ -		$ 242,092	$204,112.00	$355,245.00	$ 559,357	0.432804
7300	DRUGS CHARGED TO PATIENTS	$838,414.00	$ -	$ -		$ 838,414	$1,414,696.00	$1,591,308.00	$ 3,006,004	0.278913

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
9000	CLINIC	$205,441.00	$ -	$ -		$ 205,441	$0.00	$33,841.00	$ 33,841	6.070772
9100	EMERGENCY	$1,822,526.00	$ -	$ -		$ 1,822,526	$65,782.00	$3,749,119.00	$ 3,814,901	0.477739
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
	Total Ancillary	$ 9,166,972	$ -	$ -		$ 9,166,972	$ 3,958,068	$ 13,891,198	$ 17,849,266	
	Weighted Average									0.580005
	Sub Totals	$ 13,837,136	$ -	$ -		$ 11,278,945	$ 4,842,298	$ 13,891,198	$ 18,733,496	

	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$631,049.00
	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
11	Other Cost Adjustments (support must be submitted)	
	Grand Total	$ 10,647,896
	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

e A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (mm/dd/yyyy-mm/dd/yyyy) [redacted] WILLS MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,591.54		50		2		95		97				15		244		44.50%
2	03100 INTENSIVE CARE UNIT	$ -														-		
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ -														-		
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			Total Days	50		2		95		97		-		15		244		19.82%
19	Total Days per PS&R or Exhibit Detail			50		2		95		97		-		15				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
21	Routine Charges			Routine Charges $ 25,500		Routine Charges $ 1,020		Routine Charges $ 48,450		Routine Charges $ 49,470		Routine Charges $ -		Routine Charges $ 7,650		Routine Charges $ 124,440		14.84%
21.01	Calculated Routine Charge Per Diem			$ 510.00		$ 510.00		$ 510.00		$ 510.00		$ -		$ 510.00		$ 510.00		
	Ancillary Cost Centers (from W3 C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		1.599053	1,481	5,772	1,295	7,511	15,887	30,724	6,711	129,129	-	-	5,550	43,578	$ 25,374	$ 173,133	33.37%
23	5000 OPERATING ROOM		2.307756	-	-	-	4,813	280	8,552	280	17,451	-	-	-	-	$ 560	$ 30,816	29.90%
24	5400 RADIOLOGY-DIAGNOSTIC		0.377817	20,033	94,207	6,311	192,678	60,697	60,504	44,721	437,191	-	6,789	7,571	312,372	$ 131,762	$ 784,530	36.84%
25	6000 LABORATORY		0.612212	34,216	104,543	6,195	173,364	62,437	66,867	67,223	289,629	-	3,131	24,199	256,978	$ 150,071	$ 834,443	43.35%
26	6500 RESPIRATORY THERAPY		0.911985	11,786	24,343	1,494	48,179	24,037	25,278	36,956	112,995	-	97	5,730	34,256	$ 74,273	$ 211,695	17.24%
27	6600 PHYSICAL THERAPY		0.725828	657	6,237	291	26,707	6,155	19,572	3,833	50,114	-	258	291	1,164	$ 10,936	$ 102,730	6.16%
28	6700 OCCUPATIONAL THERAPY		0.568132	689	-	291	8,032	5,103	7,359	1,788	13,523	-	-	230	1,175	$ 7,661	$ 28,914	7.24%
29	6800 SPEECH PATHOLOGY		2.027048	187	-	-	451	785	1,241	-	902	-	-	167	-	$ 952	$ 2,634	6.47%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.432894	8,009	18,268	1,596	33,571	12,770	10,466	18,519	58,371	-	812	2,902	37,715	$ 42,894	$ 118,815	36.63%
31	7200 DRUGS CHARGED TO PATIENTS		0.278913	57,438	27,998	5,714	68,117	116,402	39,307	105,621	411,130	-	1,842	15,459	156,373	$ 285,175	$ 646,551	33.48%
32	9000 CLINIC		8.070772	-	666	280	610	-	1,925	280	9,504	-	306	-	672	$ 560	$ 12,905	42.66%
33	9100 EMERGENCY		0.477739	8,659	197,220	2,518	545,908	29,724	95,022	22,807	473,631	-	13,894	6,470	556 007	$ 73,708	$ 1,311,781	51.51%
34			-													$ -	$ -	
35			-													$ -	$ -	
38			-													$ -	$ -	
37			-													$ -	$ -	
38			-													$ -	$ -	
39			-													$ -	$ -	
40			-													$ -	$ -	
41			-													$ -	$ -	
42			-													$ -	$ -	
43			-													$ -	$ -	
44			-													$ -	$ -	
45			-													$ -	$ -	
46			-													$ -	$ -	
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67			-													$ -	$ -	
68			-													$ -	$ -	
69			-													$ -	$ -	
70			-													$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (06/01/2021-04/30/2024) WILLS MEMORIAL HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
			$ 134,135	$ 477,594	$ 25,974	$ 1,109,991	$ 325,277	$ 367,597	$ 318,739	$ 2,003,467	$ -	$ 30,028	$ 68,568	$ 1,400,090	$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (w/o Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
Total Charges *(Includes organ acquisition from Section J)*	$ 159,635	$ 477,594	$ 28,994	$ 1,109,891	$ 373,727	$ 387,597	$ 368,209	$ 2,003,467	$ -	$ 30,028	$ 78,218 (Agrees to Exhibit A)	$ 1,400,090 (Agrees to Exhibit A)	$ 928,564	$ 3,958,548	34.84%
Total Charges per PS&R or Exhibit Detail	$ 159,635	$ 477,594	$ 28,994	$ 1,109,891	$ 373,727	$ 387,597	$ 368,209	$ 2,003,467	$ -	$ 30,028	$ 78,218	$ 1,400,090			
Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
Total Calculated Cost (Includes organ acquisition from Section J)	$ 140,351	$ 249,977	$ 18,351	$ 568,865	$ 315,787	$ 249,697	$ 318,156	$ 1,181,990	$ -	$ 15,239	$ 64,988	$ 707,105	$ 790,645	$ 2,230,529	35.46%
Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 82,981	$ 200,755			$ 37,473	$ 15,657	$ 9,803	$ 18,917					$ 130,257	$ 235,399	
Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 8,346	$ 345,617			$ 2,360	$ 3,966					$ 10,706	$ 349,783	
Private Insurance (including primary and third party liability)	$ 18,915	$ 107					$ 4,399	$ 99,890					$ 23,314	$ 99,997	
Self-Pay (including Co-Pay and Spend-Down)		$ 24		$ 174		$ 536	$ -	$ 2,122		$ 3			$ -	$ 2,856	
Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 101,896	$ 200,888	$ 8,346	$ 345,991											
Medicaid Cost Settlement Payments (See Note B)		$ (5,029)											$ -	$ (5,029)	
Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 157,290	$ 139,916	$ 10,308	$ 11,643					$ 167,604	$ 150,559	
Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 183,629	$ 909,378					$ 183,629	$ 909,378	
Medicare Cross-Over Bad Debt Payments					$ 4,387	$ 40,497					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 4,387	$ 40,497	
Other Medicare Cross-Over Payments (See Note D)					$ 110,845	$ 47,735	$ 22,180	$ 2,130					$ 133,025	$ 49,865	
Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 8,504	$ 82,340			
Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	$ 38,455	$ 54,120	$ 10,005	$ 222,874	$ 5,788	$ 6,358	$ 83,477	$ 113,874	$ -	$ 15,238	$ 56,484	$ 844,765	$ 137,723	$ 397,224	
Calculated Payments as a Percentage of Cost	73%	78%	45%	61%	98%	97%	74%	90%	0%	0%	13%	9%	83%	82%	

Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 8) 449
Percent of cross-over days to total Medicare days from the cost report 21%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with surve
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payment
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

Out-of-State Medicaid Data:

t Report Year (05/01/2023-04/30/2024) | WILLS MEMORIAL HOSPITAL

e #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
utine Cost Centers (list below):				Days		Days		Days		Days		Days	
00	ADULTS & PEDIATRICS	$ 1,591.54										-	
00	INTENSIVE CARE UNIT	$ -										-	
00	CORONARY CARE UNIT	$ -										-	
00	BURN INTENSIVE CARE UNIT	$ -										-	
00	SURGICAL INTENSIVE CARE UNIT	$ -										-	
00	OTHER SPECIAL CARE UNIT	$ -										-	
00	SUBPROVIDER I	$ -										-	
00	SUBPROVIDER II	$ -										-	
00	OTHER SUBPROVIDER	$ -										-	
00	NURSERY	$ -										-	
		$ -										-	
		$ -										-	
		$ -										-	
		$ -										-	
		$ -										-	
		$ -										-	
			Total Days	-		-		-		-		-	
l Days per PS&R or Exhibit Detail				-		-		-		-		-	
	Unreconciled Days (Explain Variance)			-		-		-		-		-	
	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
iliary Cost Centers (from W/S C) (list below):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
00	Observation (Non-Distinct)		1.599052		-		-				-	$ -	$ -
00	OPERATING ROOM		2.307756		-		-				-	$ -	$ -
00	RADIOLOGY-DIAGNOSTIC		0.377817		1,990		2,362				1,990	$ -	$ 6,342
00	LABORATORY		0.612212		108		822				-	$ -	$ 930
00	RESPIRATORY THERAPY		0.911985		525		-				-	$ -	$ 525
00	PHYSICAL THERAPY		0.725828		-		-				-	$ -	$ -
00	OCCUPATIONAL THERAPY		0.568132		-		-				-	$ -	$ -
00	SPEECH PATHOLOGY		2.027048		-		-				-	$ -	$ -
00	MEDICAL SUPPLIES CHARGED TO PATIENT		0.432804		233		264				178	$ -	$ 675
00	DRUGS CHARGED TO PATIENTS		0.278913		656		652				-	$ -	$ 1,308
00	CLINIC		6.070772		-		-				-	$ -	$ -
00	EMERGENCY		0.477739		1,416		2,672				-	$ -	$ 4,088
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
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			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -

Out-of-State Medicaid Data:

[redacted] Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
[redacted]	[redacted]	-							-		$ -	$ -
		-									$ -	$ -
		-									$ -	$ -
		-						

I. Out-of-State Medicaid Data:

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
10													
11			-									$ -	$ -
2			-									$ -	$ -
3			-									$ -	$ -
4			-									$ -	$ -
5			-									$ -	$ -
6			-									$ -	$ -
7			-									$ -	$ -
3			-									$ -	$ -
)			-									$ -	$ -
)			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
Totals / Payments				$ -	$ 4,927	$ -	$ 6,772	$ -	$ -	$ -	$ 2,168		

	FFS Primary		MC Primary		Cross-Overs		Other Eligibles		Total	
Total Charges (includes organ acquisition from Section K)	$ -	$ 4,927	$ -	$ 6,772	$ -	$ -	$ -	$ 2,168	$ -	$ 13,868
Total Charges per PS&R or Exhibit Detail	$ -	$ 4,927	$ -	$ 6,772	$ -	$ -	$ -	$ 2,168		
Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
Total Calculated Cost (includes organ acquisition from Section K)	$ -	$ 2,257	$ -	$ 2,968	$ -	$ -	$ -	$ 829	$ -	$ 6,054
Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 62							$ -	$ 62
Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 1,319					$ -	$ 1,319
Private Insurance (including primary and third party liability)									$ -	$ -
Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 62	$ -	$ 1,319						
Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)									$ -	$ -
Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
Medicare Cross-Over Bad Debt Payments									$ -	$ -
Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	$ -	$ 2,195	$ -	$ 1,649	$ -	$ -	$ -	$ 829	$ -	$ 4,673
Calculated Payments as a Percentage of Cost	0%	3%	0%	44%	0%	0%	0%	0%	0%	23%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (05/01/2023-04/30/2024) WILLS MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*				(WTB Account #)
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*				(Where is the cost included on w/s A?)
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -		
3	Difference (Explain Here ——>)	CAH			
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				(Reclassified to / (from))
5	*Reclassification Code*				(Reclassified to / (from))
6	*Reclassification Code*				(Reclassified to / (from))
7	*Reclassification Code*				(Reclassified to / (from))
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				(Adjusted to / (from))
9	*Reason for adjustment*				(Adjusted to / (from))
10	*Reason for adjustment*				(Adjusted to / (from))
11	*Reason for adjustment*				(Adjusted to / (from))
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	Charges Sec. G	4,931,008
19	Uninsured Hospital	Charges Sec. G	1,476,309
20	Total Hospital	Charges Sec. G	18,733,496
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to Include in DSH Medicaid UCC***		26.32%
22	Percentage of Provider Tax Assessment Adjustment to Include in DSH Uninsured UCC		7.88%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	Charges Sec. G	1,785,813
27	Uninsured Hospital	Charges Sec. G	1,506,337
28	Total Hospital	Charges Sec. G	18,733,496
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to Include in DSH Medicaid UCC***		9.53%
30	Percentage of Provider Tax Assessment Adjustment to Include in DSH Uninsured UCC		8.04%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		$ -

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*

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